



Handbook for Providers of Optometric Services

Chapter O-200 Policy and Procedures for Optometric Services

Illinois Department of Healthcare and Family Services

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CHAPTER O-200

Optometric Services

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of opticians, optical companies, optometrists, and ophthalmologists who provide vision care services to participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

Limited guidance is contained in this handbook for the provision of medical diagnostic and therapeutic services for the eyes. Additional guidance for such medical services, whether provided by optometrists or by physicians, can be found in the Handbook for Practitioners Rendering Medical Services, Chapter A-200.

This [handbook](#) can be viewed on the Department's Web site.

This handbook provides information regarding specific policies and procedures relating to optometric services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The [updates](#) will be posted to the Department's Web site.

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 877-782-5565. The call is toll-free.

CHAPTER O-200

OPTOMETRIC SERVICES

O-200 BASIC PROVISIONS

For consideration for payment by the Department for optometric services, such services must be provided by an optometrist, ophthalmologist, optician or optical company enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general provisions contained in the [Chapter 100](#), Handbook for Providers of Medical Services, General Policy and Procedures that can be found on the Department's Web site and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms. Providers billing for the dispensing of eyewear or for any optical supply use the HFS 1443 Provider Invoice for billing paper claims. All other services, including vision examination codes, are billed on the HFS 2360 Health Insurance Claim Form. Providers wishing to submit X12 or NCPDP electronic transactions must refer to the [Chapter 300](#), Handbook for Electronic Processing found on the Web site.

Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

O-201 PROVIDER PARTICIPATION

O-201.1 PARTICIPATION REQUIREMENTS

An optometrist who holds a valid Illinois (or state of practice) license to practice optometry is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Optometrists holding non-teaching administrative or staff positions in schools or other institutions may be approved for participation in the provision of direct services if they maintain a private practice.
- Teaching optometrists who provide direct services may be approved for participation provided that salaries paid by schools or other institutions do not include a component for treatment services.

No license is required for enrollment as an optician or optical company, but the provider must be in compliance with relevant state laws in the state in which he or she is doing business.

Participation requirements for ophthalmologists are covered in Chapter A-200, the Handbook for Practitioners Rendering Medical Services. See Topic O-220 for instructions on obtaining this handbook.

The provider must be enrolled for the specific category of service for which charges are to be made.

The categories of service for which an optometrist may enroll are:

- Category 001 – Physician Services
- Category 003 – Optometric Services
- Category 045 – Optical Materials

Opticians and optical companies may only enroll for Category of Service 045 – Optical Materials.

Procedure: The provider must complete and submit:

- \$ Form HFS 2243 (Provider Enrollment/Application)
- \$ Form HFS 1413 (Agreement for Participation)
- \$ Form HFS 2307 (Hospital, Professional School or Group Practice as Alternate Payee, if applicable)
- \$ Form HFS 2306 (Power of Attorney, if applicable)
- \$ W9 (Request for Taxpayer Identification Number)

These [forms](#) may be obtained from the Department's Web site. Providers may also request the enrollment forms by [e-mail](#).

Providers may call the unit at 217-782-0538 or mail a request to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment, unless the provider requests a specific enrollment date and it is approved by the Department.

O-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix O-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic O-201.4.

O-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

O-201.4 PROVIDER FILE MAINTENANCE

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of changes or corrections may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status, or the provider submits a change, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed, if the payee address is different from the provider address.

O-202 PROVIDER REIMBURSEMENT

The Department uses the Illinois Department of Corrections (DOC) for fabrication of eyeglasses. Optometrists will be reimbursed for professional services and, if appropriate, a dispensing fee for eyeglasses. Except as provided in Topic O-212.5, providers will not be reimbursed for the fabrication or sale of eyeglasses.

When billing for services or materials or both, the claim submitted for payment must include a description of the actual services provided or the materials dispensed. Any payment received from a third-party payer, a program participant or other persons incidental to examination or provision of glasses must be reflected as a credit on any claim submitted to the Department bearing charges for covered services. (Exception: Department co-payments, when applicable, are not to be reflected on the claim).

If a patient has a third party insurance and chooses not to order eyewear through the DOC lab, the Department will not reimburse the patient or the provider any balance due from the cost of that eyewear.

O-202.1 CHARGES

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service has been provided.

Providers may charge only for services they personally provide, or which are provided under their direct supervision in their offices by their staff, e.g., dispensing done by a technician in a provider's employ.

A provider may not charge, however, for services provided by another provider, even though one may be in the employ of the other.

Providers may not charge for services provided outside their offices by anyone other than themselves.

Optometrists (Provider Type 12) may bill the Department fee-for-service for services and items provided to participants enrolled in a Managed Care Organization (MCO).

Allowable Charges By Teaching Optometrists

Teaching optometrists who provide direct patient care may submit charges for the services provided, if the salary paid them by the school or other institution does not include a component for treatment services.

Charges are to be submitted only when the teaching optometrist seeking reimbursement has been personally involved in the services being provided. This means presence in the room performing or supervising the major phases of the services, with full and immediate responsibility for all actions performed as a part of the testing or examination. The patient's record must be documented to show these requirements have been met. All such entries must be signed and dated by the optometrist seeking reimbursement.

O-202.2 ELECTRONIC CLAIM SUBMITTAL

Providers may submit claims electronically, using the X-12 837 Professional Standard. Refer to Chapter 300, Handbook for Electronic Processing. Providers may also submit claims directly to the Department via the Internet through the MEDI IEC system. Further information regarding [MEDI IEC](#) can be found on the Department's Web site.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor, if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

O-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services, and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix O-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

O-202.31 Opticians and Optical Companies

Form HFS 1443, Provider Invoice, is to be used to submit charges for covered services provided by opticians and optical companies. Charges may also be billed on the 837P electronic format. Detailed instructions for completion are included in Appendix O-1.

All services, for which charges are made, are to be coded with specific procedure codes as described in the Optometric Fee Schedule. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

O-202.32 Claims Submittal

All routine paper claims, including those with an Optical Prescription Order (OPO) Form attached, are to be submitted in a pre-addressed mailing envelope, Form HFS 1444, Provider Invoice Envelope, provided by the Department for this purpose. Routine claims with an OPO attached, and routine claims with no OPO attached, should be mailed in separate envelopes. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use Form HFS 2248, Special Handling Envelope. A non-routine claim is:

- Any claim to which Form HFS 1411, Temporary MediPlan Card, is attached.
- Any claim to which a document other than the OPO is attached.

For electronic claims submittal, refer to Topic O-202.2 above. **Non-routine claims may not be electronically submitted.**

O-202.4 PAYMENT

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge, or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department, and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

Reimbursement for Vision Examinations

The reimbursement made for the vision examination, to determine the condition of the eye, includes all services provided during the examination and associated vision care services provided as a result of examination findings, such as the writing of an Optical Prescription Order (OPO).

Reimbursement for Medical Services

When a therapeutic procedure is performed, reimbursement will be made for either the visit or the procedure, but not for both, unless it is an initial visit. On subsequent medical visits, when a procedure is performed the same day, the provider may bill both, but the Department's total payment will be capped. In calculating the cap, the Department compares the maximum rate payable for each service billed and selects the highest amount payable.

Reimbursement for Contact Lenses

Except for lenses for aphakic children under the age of three, coverage of contact lenses is subject to prior approval. Refer to Topic O-212.2.

For aphakic lenses for children under age three, providers still must submit a statement of medical necessity and a cost invoice, in order for the Department to price the lenses. The payment for contact lenses for aphakic children will be based upon the acquisition cost to the provider. The acquisition cost is defined as the actual amount the supplying provider must pay to acquire the contact lens(s), taking into account any discounts, rebates or bonuses and including all freight, postage, and delivery. Patient records should document acquisition costs.

The Department will also accept prior approval requests for the contact lens prescription and fitting service.

O-202.5 FEE SCHEDULE

[Fee schedules](#) of allowable procedure codes by provider type are on the Department's Web site.

Paper copies can be obtained by sending a written request to:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
607 East Adams Street
Springfield, IL 62701

The Optometric Fee Schedule identifies the dispensing fee and service fee codes, as well as other HCPCS codes related to optical equipment and supplies.

For all other medical procedure codes, optometrists and physicians must refer to the Practitioner Fee Schedule.

The Web site listings and the downloadable rate file are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections, or the addition of newly created HCPCS codes.

O-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services. The services covered in the program are limited and include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment. See the Optometric Fee Schedule on the Department's Web site for services covered in the optometric program and for procedure codes to be used when billing for services provided or materials dispensed.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

The provision of glasses and other materials that are required to restore and conserve vision are a covered service. All lenses and frames are to be obtained from the Department of Corrections (DOC) laboratory.

Optical Prescription Order (OPO) forms must be attached to the paper claim for the dispensing fee, if eyeglasses are being ordered. The Department will forward the OPO to DOC. The Department will reimburse DOC directly for the lenses and frames.

Optometrists, physicians, and optical companies may bill for the eyeglasses dispensing fee and also provide frame parts, frame repairs, contact lenses, artificial eyes and low vision devices. Some of these services are subject to prior approval, as described in Topic O-211. **Only optometrists and physicians may bill for examinations.**

Any question a provider may have about coverage of a particular service is to be directed to the Department prior to provision of the service. Providers may call the Bureau of Comprehensive Health Services at 877-782-5565.

O-203.1 EXAMINATION TO DETERMINE THE CONDITION OF THE EYE INCLUDING THE REFRACTIVE STATE

The Department will reimburse for more than one examination per year only when the optometrist or physician documents the need for the additional examination. If more frequent care is medically necessary because of an unusual circumstance, the patient's record must be documented with an explanation of the special circumstances, and the services provided.

The eye examination must be conducted in accordance with rules promulgated by the Illinois Department of Financial and Professional Regulation, implementing the Illinois Optometric Practice Act [68 Ill. Admin. Code Part 1320](#). Those rules list the procedures comprising a minimum eye examination.

O-203.2 DISPENSING FEE

A charge may be made when eye care materials manufactured through DOC are to be dispensed, if it is the provider's usual and customary practice to make such a charge. The charge is to be no more than that made by the provider to private pay patients, and is to cover the fitting and subsequent adjustment services.

O-203.3 SERVICE FEE

A service fee may be charged when the dispensing fee is not applicable, e.g., when replacement parts are provided.

A service fee is not to be charged in combination with a dispensing fee.

O-203.4 EARLY INTERVENTION SERVICES

Early Intervention (EI) services are covered only for children up to the age of three years, who are eligible for Part H Services under the Individuals with Disabilities Education Act, and when those services are included in the child's Individualized Family Service Plan. Procedure codes for EI services must be billed to the EI Central Billing Office (CBO) for payment. In order to receive payment from the CBO, a provider must apply for, and obtain, an Early Intervention Credential, enroll as a provider with the CBO, and have prior authorization to provide services.

- For credential and enrollment information, contact Provider Connections at 1-800-701-0995.
- For questions about the service authorization and billing processes, contact the Early Intervention CBO Cornerstone Call Center at 1-800-634-8540.

O-204 NON-COVERED SERVICES

Services, for which medical necessity is not clearly established, are not covered by the Department's Medical Programs. Refer to Chapter 100, Topic 104, for a general list of non-covered services.

In addition, the following optometric services are excluded from coverage in the Department's Medical Programs, and payment will not be made for the provision of these services:

- Examination required for the determination of disability or incapacity. Local Department of Human Services offices (Family Community Resource Centers) may request that such examinations be provided, with payment authorized from nonmedical funds. Optometrists are to follow specific billing instructions given in these cases.
- Services provided in federal or state institutions

O-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110, for record requirements applicable to all providers.

Providers must maintain an office record for each patient. In group practices, partnerships and other shared practices, one record is to be kept with chronological entries by the individual optometrist, physician or optician rendering services.

The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. The signature of the provider is required for the record of the service/visit to be complete. If there is no signature, then the record is incomplete.

All entries must include the date, must be legible and be written in English. Records that are unsuitable because of illegibility or because they are written in a language other than English, may result in sanctions if an audit is conducted. Any services provided a patient by the provider outside the provider's office are to be documented in the medical record maintained in the provider's office.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition, and the treatment and services ordered and provided during the period of institutionalization, may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, and dates and times services were provided, is to be maintained by the provider as an office record to show continuity of care.

Opticians and optical companies must maintain records adequate to document items dispensed, and services provided, and to document that eyeglasses and other eye care materials are dispensed only in accordance with a prescription written by a physician or an optometrist.

The Department, and its professional advisors, regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post-payment audits.

In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

O-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services, approval must be obtained from the Department. If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

Medicare Exception: An exception to the prior approval requirements exists in situations in which services or materials requiring prior approval are provided to a patient eligible for Medicare Part B benefits and the service or material is covered in the Medicare program. Prior approval requirements are waived in instances in which Medicare payment is approved.

If Medicare denies a **service** as non-covered, the provider must submit an HFS 2360 claim form with a note for special handling to the attention of the optometric program billing consultants at the address below.

If Medicare denies a **supply or material** as non-covered, the provider may request post approval from the Department. When post approval is received for a supply or material denied by Medicare, the provider is to submit an HFS 1443 claim form with a note for special handling to the attention of the optometric program billing consultants at the following address:

Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115
Attn: Optometric Billing Consultant

=O-211.1 PRIOR APPROVAL REQUESTS*Effective July 1, 2012*

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

If the provider does not submit sufficient information for a determination, the Department sends a letter to the provider requesting additional information. If, after 30 days, the provider has not responded, the Department will generate a denial letter to the provider and patient.

The following services and materials may be provided only with prior approval of the Department:

- Contact lens/lenses and related service
- Custom-made artificial eye
- Low vision devices
- Polycarbonate eyeglass lenses for adults, age 21 and over (see Appendix O-2a for specific information).
- Eyeglasses fabricated by suppliers other than DOC
- Service/materials not otherwise identified on the schedule of procedures for optical services and supplies.

Refer to the Optometric Fee Schedule on the Department's Web site for the billing codes of the vision care services that require prior approval. If the code is hand-priced, the Department requires an invoice from the supplier verifying the cost.

Procedure: Prior approval to dispense or provide the above described service or material is to be requested by the provider using Form HFS 1409, Prior Approval Request. See Appendix O-2 for instructions for completing Form HFS 1409. Requests may be mailed to the Department in the Form HFS 2300, Prior Approval Request Envelope. Requests may also be faxed to the optometric prior approval unit at 217-524-7120.

The Department generates a letter, to both the provider and the patient, of the Department approval or disapproval of the prior approval request. The approval letter does include the amount approved for the item.

When billing for a service or material that has been approved for a patient, the claim is to be submitted to the Department as a routine claim on the HFS 1443.

O-212 LIMITATIONS AND CONSIDERATIONS ON SPECIFIC ITEMS

The lens materials for eyeglasses available through the DOC laboratory are:

- Glass
- Plastic
- Polycarbonate. Polycarbonate lenses are available for all children through age 20, and adults with prior approval and a prescription of +/- 2.5.

The guidelines for what lenses can be manufactured at DOC are:

- Glass
- Plastic – no limits
- Polycarbonate – single vision, maximum is +8.50 and bifocal maximum is +8.0. Minus has no upper limit.

O-212.1 LENSES

Single Vision Lenses

Lenses are covered only if the power is at least ± 0.75 diopters, in either the sphere **or** cylinder component.

A change of lenses is a covered service only when there is a change of at least ± 0.75 diopters, in either the sphere **or** cylinder component.

Bifocal Lenses

Bifocal lenses are covered only if the power of the bifocal addition is ± 1.00 diopter or more. A change in lenses is covered if the distance power meets the minimum change requirements (± 0.75 diopters), or if the power of the bifocal addition is changed by at least ± 0.50 diopters.

Change From Single Vision to Bifocal or Bifocal to Single Vision

When changing from a single vision to bifocal, the distance component must meet the minimum prescription requirement (± 0.75 diopters), **or** the resultant total power of the new prescription must meet the requirement for a change in prescription (± 0.75 diopters).

When changing from bifocal to single vision, the new prescription must meet the requirement for a change in prescription (± 0.75 diopters) figured from the resultant total power of the bifocal prescription, **and** the new prescription must meet the minimum prescription power requirement (± 0.75 diopters).

O-212.2 CONTACT LENSES

Contact lenses require prior approval, except when provided to aphakic children age 0 to 3 (see Topic O-202.4). Consideration will be given to approving contact lenses only when there is a documented medical need, a diagnosis of Monocular Aphakia, a pathological condition of the cornea, or when useful vision cannot be obtained with glasses.

Requests for approval of contact lenses must include information explaining why the patient cannot be satisfactorily fitted with conventional lenses, and a report of the patient's best spectacle lens prescription and the visual acuity achieved with contacts and with glasses.

The Department will accept prior approval requests for the contact lens prescription and fitting service, whenever the provider believes it is medically necessary for the patient to receive this service. The prescription and fitting service must meet the criteria as set forth in *Current Procedural Terminology (CPT®), Fourth Edition*.

O-212.3 CUSTOM-MADE ARTIFICIAL EYES

Custom-made artificial eyes are subject to prior approval and are covered only when the patient is unable to wear a stock plastic eye. All prior approval requests must include information as to why a stock artificial eye is not appropriate to meet the patient's need.

O-212.4 LOW VISION DEVICES

Prisms meeting the minimum power requirement do not require prior approval and may be prescribed when the medical need exists. The requirements are met only when the combined vertical prism power is at least ± 2 prism diopters, or the combined horizontal prism power is at least ± 5 prism diopters.

Low vision devices other than eyeglasses and prisms are covered only with prior approval. Requests for prior approval to dispense low vision corrective devices must include information explaining in detail the patient's need for the device. Additionally, the request is to include the cost of the device, the life expectancy of the device, and the manufacturer. Convenience items will not be covered.

O-212.5 FABRICATION OF GLASSES BY SUPPLIERS OTHER THAN DOC

Fabrication of glasses by a supplier other than the Department of Corrections is covered only with prior approval. Requests for prior approval must include sufficient detail on the type of lens or frame, to determine that DOC cannot manufacture them. The request must also include information explaining why a standard pair of glasses is not medically appropriate to meet the patient's need.

O-212.6 ITEMS NOT OTHERWISE IDENTIFIED

Services or materials that are not identified on the Optometric or Practitioner Fee Schedules require prior approval. Information must be submitted describing in detail the material or service to be provided. A history of past treatment provided is required. Additionally, the request for approval must show why the material or service is better than any other commonly used to deal with similar diagnoses or conditions. All items or services requested must be medically necessary.

O-212.7 FREQUENCY OF SERVICES**=O-212.71 Adult Services**

Effective July 1, 2012

Eyeglasses for adults are covered if medically necessary. Adult participants who are 21 years of age and older are limited to one pair of eyeglasses in a two-year period. As of July 1, 2012, the Department will begin a two-year (730 days) count from the date of the last pair of eyeglasses ordered to determine eligibility for a new pair.

Example: A patient last ordered eyewear with a date of service May 1, 2012. The Department will count forward from that service date to determine eligibility for another pair of eyeglasses.

The Department will deny any prior approval requests submitted for additional adult eyewear beyond the stated limit.

This policy does not limit medically necessary eye examinations, or claims for repair/refitting of eyeglasses.

O-212.72 Children's Services

For children through age 20, eyeglasses are replaced as needed through the DOC laboratory, with no prior approval required.

O-220 OFFICE SERVICES

If billing on the paper claim format, optometrists and physicians bill all services, except the dispensing fee and any other supply, on the HFS 2360 claim form. The dispensing fee and supplies are billed on the HFS 1443 paper claim form.

For optometric examinations, providers should use one of the following combinations of codes to designate a full optometric exam:

Procedure Code 92015 –*Determination of Refractive State*, with

- The appropriate Evaluation and Management code in the *Current Procedural Terminology (CPT®), Fourth Edition*, **or**
- One of the general ophthalmologic services codes in range 92002 through 92014 of the CPT.

Providers should follow the CPT definitions of services, and bill the code for the level of service rendered.

The Handbook for Practitioners Rendering Medical Services delineates general coverage, coding and documentation requirements and coverage restrictions for medical, diagnostic and treatment services provided in the office.

Copies of the [Handbook for Practitioners Rendering Medical Services](#) may be downloaded from the Department's Web site.

Copies may also be obtained by contacting the Provider Participation Unit at:
Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
E-mail: hfs.ppu@illinois.gov
Fax number: 217-557-8800 Attn: PPU

When an optometrist shares a partnership or group practice with another optometrist or a physician, the same policies and billing limitations apply to all members in the same group practice. For example, a patient may be designated as a new medical patient for billing purposes only once collectively for all practitioners in the partnership or group, regardless of how many practitioners in the group practice eventually see the patient.

O-235 PROVISION OF EYEGLASSES AND OPTICAL MATERIALS

All eyeglasses are fabricated through the eyeglasses laboratory at Dixon Correctional Facility.

A patient may utilize any participating optometrist or physician for an examination. If eyewear is needed, the patient may choose to order his or her eyewear from that same optometrist or physician, or may take his or her prescription to a participating optician or optical company.

The patient has freedom of choice to order eyewear from any participating optometrist, physician, optician or optical company. If a patient requests his prescription, the optometrist or physician must provide it.

O-235.1 ORDERING OF FRAME BOARDS

The Department utilizes the Department of Corrections (DOC) for fabrication of eyeglasses. DOC supplies a display board to providers of the available eyeglass frames. To obtain a display board, the provider must contact DOC directly.

Procedure: Contact DOC at the following address and telephone number:

Dixon Correctional Facility Industries
Post Office Box 809
Dixon, Illinois 61021
Phone: 1-800-523-1487 (toll free)

O-235.2 ORDERING OF EYEGLASSES

The Optical Prescription Order (OPO), Form HFS 2803, is to be used to order lenses or frames or both. The OPO is to be submitted with the paper HFS 1443 claim form to the Department. The claim will show charges for the dispensing fee, not lenses and frames. Upon receipt, the Department will enter the claim into the Claims Processing System, and forward the OPO for fabrication of eyeglasses to DOC. When the claim has completed editing for patient eligibility and for previous eyeglasses utilization, the Department will authorize DOC to fabricate the eyeglasses. DOC will mail the eyeglasses directly to the ordering provider. Eyeglasses are to be dispensed to the patient upon receipt from DOC.

It is important for providers to submit the claim and OPO as soon as possible after the patient has been seen to initiate the processing of the eyeglasses order. Delaying the claim and OPO submission only adds to the time the patient must wait for the eyewear.

If the dispensing fee billed on the claim is not payable for any reason, the claim is rejected and the rejection is reported on the Remittance Advice. In this situation, the Remittance Advice will also indicate whether or not the eyeglasses are being fabricated.

If the Remittance Advice shows that eyeglasses **are** being fabricated, and the error that caused the claim to reject is correctable, the provider should submit a new Provider Invoice **without** an OPO attached. This claim must be submitted with a note for special handling to the attention of the optometric program billing consultants at the following address:

Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115
Attn: Optometric Billing Consultant

If the Remittance Advice shows that eyeglasses **are not** being fabricated, and the claim rejected due to a correctable error, the provider should submit a new Provider Invoice **with** an OPO attached.

O-235.3 QUALITY ASSURANCE

The agreement between the Department and DOC provides that DOC is responsible for monitoring the quality of the finished product. Therefore, if the ordering provider finds that the eyeglasses received from DOC do not conform to the prescription order the provider submitted, or that the finished product is defective, this is to be reported directly to DOC for resolution and refabrication of the eyeglasses, if necessary.

Procedure: Contact DOC at the address or phone number shown in Topic O-235.1.

The ordering or dispensing provider will not be held accountable for the cost of replacement eyeglasses or parts, when the error is attributable to DOC or to the Department.

If the ordering provider or the patient finds that the eyeglasses are not usable due to error in how the prescription was written, the ordering provider must arrange for fabrication of new eyeglasses at his or her own expense. The DOC laboratory is not to be used. Additionally, neither the Department nor the patient is to be billed.

O-235.4 REPLACEMENT OF BROKEN LENSES

If one or both lenses are broken, but the frame is still usable, the lens or lenses are to be ordered from DOC by completing an OPO and a claim containing a charge for the service fee, and sending both documents to the Department. The OPO must identify the frame for which DOC is being asked to fabricate a new lens or lenses. The new lens or lenses will be sent directly to the provider for insertion into the frame.

O-235.5 FRAME, FRAME PARTS AND REPAIRS

Except as provided in Topic O-212.5, only DOC frames are covered by the Department. A replacement frame may be covered only when the present frame is broken, and is non-repairable, or has been lost. In instances where it is evident that the repair of an existing frame is less costly than providing a new frame, and when such repairs provide a serviceable frame for the patient, consideration is to be given to repairing the existing frame. New frame parts, including fronts, temples, etc., are covered when used to repair an existing frame.

Procedure: If the frame that has a broken frame front or temple is a DOC frame, the part is to be ordered from DOC by completing the OPO and the claim, and sending both to the Department. The OPO should clearly identify the frame and provide relevant parts specifications. The claim should contain a service fee charge.

If the frame that has a broken frame front or temple is not a DOC frame but the provider can furnish the replacement part, the provider completes the service and bills both the part and the service fee on the claim. No OPO is completed or attached to the claim.

If the frame that has a broken frame front or temple is not a DOC frame and the provider cannot furnish the replacement part, new eyeglasses (complete glasses) may be ordered from DOC by completing the OPO and the claim, and sending both documents to the Department.

O-270 HOME AND LONG-TERM CARE FACILITY SERVICES

A provider may provide a covered service to a patient in the patient's place of residence (private home or long-term care facility), when the patient is physically unable to go to the provider's office.

Charges may be made for the examination, or for the services the provider provided at the time of a home visit, in accordance with policy and procedures applicable to office services, and within the limitations and requirements specified in Topics O-270.1 and O-270.2, for services provided in long-term care facilities.

No charges may be made for services provided to residents in a long-term care facility by a provider who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) of such facility, except:

1. for emergency services provided for acute illness, or
2. when essential treatment facilities are not available in the vicinity for short-term care pending transfer, or
3. when there is not a comparable facility in the area.

Charges may not be made for services to residents in a long-term care facility by a provider who receives reimbursement from the facility for direct patient care services.

O-270.1 LONG-TERM CARE FACILITY LIMITATIONS AND REQUIREMENTS - VISION EXAMINATIONS AND REFRACTIONS

To be considered for reimbursement, vision examinations and refractions performed in a long-term care facility must meet the requirements in Topic O-203.1.

Non-essential visits to residents in long-term care facilities are not allowed, and payment will not be made for such care. Such care includes screening services.

All services provided by the provider to residents in long-term care facilities are to be documented by the provider in the resident's record, which is maintained by the facility. **The record must be documented with the reason for the visit, including the name of the individual requesting the service.** See also Topic O-205.

O-270.2 LONG-TERM CARE FACILITY LIMITATIONS AND REQUIREMENTS - MEDICAL SERVICES PROVIDED BY AN OPTOMETRIST

Except for emergency services provided when the attending physician is not available, an optometrist may not charge for medical services to a resident in a long-term care facility, unless the attending physician has made a referral with the resident's knowledge and permission. Charges are not to be submitted for routine visits that are made without individual referrals by the attending physician. Referrals must be specific to the medical condition or need of the resident.

Visits made to residents eligible for Medicare benefits will be disallowed if determined not medically necessary by Medicare.

O-283 SURGICAL SERVICES

Reimbursement to a physician for certain surgical services includes the presurgical examination and complete postoperative care for a period of 30 days. Other practitioners, including optometrists, may bill for medical visits during this period only for conditions or diagnoses unrelated to the surgery. A narrative explanation of the medical necessity for such care must be submitted with each claim. Please refer to the Handbook for Practitioners Rendering Medical Services for additional information.

